Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/dermconsult/personalized-systemic-therapy-atopic-dermatitis-prurigo-nodularis/51039/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Personalizing Systemic Therapy in Atopic Dermatitis and Prurigo Nodularis

Announcer:
This is *DermConsult* on ReachMD, and this episode is sponsored by Galderma. Here's your host, Dr. Raj Chovatiya.

Dr. Chovatiya:
Welcome to *DermConsult* on ReachMD. I'm Dr. Raj Chovatiya, Associate Professor at the Rosalind Franklin University of Medicine and Science, Chicago Medical School, and Founder and Director of the Center for Medical Dermatology and Immunology Research in Chicago. Joining me today to discuss how we can integrate systemic therapies into personalized management of atopic dermatitis and prurigo nodularis is none other than the great Dr. Peter Lio. He's a Clinical Assistant Professor at the Northwestern Medicine Feinberg School of Medicine in Chicago and a wonderful friend over the years. Dr. Lio, thanks for being here today.

Dr. Lio:
Thank you so much for having me.

Dr. Chovatiya:
Dr. Lio, let's dive right in. Could you share some real-world cases where persistent pruritus was the main factor driving treatment escalation in patients with atopic dermatitis or prurigo nodularis?

Dr. Lio:
Absolutely, thank you. And I think both of us know that this really is a distinct subset of patients where they might look a lot better—maybe they are responding to the topical therapy—but they don't feel better; they're still really itchy and uncomfortable, and it's having an impact on their quality of life.

I sometimes joke about it, but patients will be doing a televisit—I do two days of teledermatology—and inevitably, there's some problem with the camera or with the internet and it's kind of crummy. And the patient's very concerned and I say, "Hey, listen, don't worry. I can do this blind to some degree because ultimately, what matters most is what you're telling me." Literally, I give them an example just like this: some patients look really good, but they tell me they're not where they need to be. So that's going to always supersede the way you look. And I think that's very reassuring to patients.

But it also is a real problem because then you have to think, okay, what am I going to do? Are we going to just escalate our topicals? Are we going to go to a more powerful systemic therapy, one that's potentially even more immunosuppressive like one of our legacy immunosuppressants, or are we going to try to look for something that maybe specifically targets itch?

Dr. Chovatiya:
Before we jump into therapy, I want to zoom in here on the disease states themselves. Are there differences when you're thinking about pruritus with atopic dermatitis or prurigo nodularis? I know there are distinct conditions, but both can really make patients miserable with the severe degree of itch involved. Is there any clear differentiating factors you think about?

Dr. Lio:
I do think of them as pretty similar, and to me, I'm a little bit more of a lumper than a splitter, so I do view that many of my prurigo cases seem to be connected to atopic dermatitis. But I think we know from the literature, especially, that the prurigo itch tends to be deeper and tends to be, on average, higher. And it sounds like that's probably the group of patients with the highest itch burden of all, but I think they are connected in many ways.

Dr. Chovatiya:

Now when you're taking care of these patients, Dr. Lio—and you kind of touched on this when thinking about some of our old fashioned therapies and some of our newer therapies—how do you approach that process of selecting systemic therapy?

Dr. Lio:
If they're 12 to 18, then we really only have the atopic dermatitis indication for these drugs. Once we're 18 and over, I wish I had an easy elevator pitch about why I pick what I pick. But part of it is going to be going through the sort of shared decision-making process with the patient. I like to talk about the pluses and the minuses.

But one of the things that's interesting about the new landscape that we have is that if it's itch dominant or if itch tends to be a real serious issue for the patients, then I think while dupilumab, lebrikizumab, tralokinumab are all very similar in their ability to help both skin and itch, it really does seem like nemolizumab stands above the crowd for being perhaps a bit faster and a bit better for itch.

The other big issue that comes up now—and I didn't necessarily foresee this early in development, but now that the medicines are out and we get to talk about them—is the dosing. So for people that are concerned about the needles or people that are worried about the frequency, we know with those three we just mentioned—the first three that work on the IL-13 pathway—they all begin at every two-week dosing. Nemolizumab begins at every four-week dosing, which doesn't sound like a lot, but then if they're doing better, they can go to every eight-week dosing. And that's a big deal; it's a bigger deal than I think I recognized.

And then finally, regarding the tolerability of the injection, one of those things I literally only learned after having personally administered it to a few patients is that nemolizumab, the injection itself, tends to be pretty minimal. It's a small volume of fluid—about half a CC as opposed to two CCs—and the needle's very tiny. So many patients, it's hilarious, they're like, "I'm ready," and I'm like, "No, you're done. I already did the injection." They're like, "Wait, really? I didn't feel it." So that's something also to keep in mind.

I'd love to hear your thoughts because you treat a lot of these patients as well for AD and then maybe you could tell us a little bit of how you view prurigo as well.

Dr. Chovatiya:
I'd say that our approach is relatively similar in that we are beginning to arrive at a point where it's almost an embarrassment of riches in a good way because we have to come up with some of these algorithms for how we parse things out.

I think that with atopic dermatitis, oftentimes, as you mentioned, when really itch is at the forefront, the discussion and speed is at the forefront of discussion. You start to think about certain therapies more than others. Nemolizumab, as you mentioned, based on the ability to have fast onset and very quick relief also tends to be one that comes to the top.

I think that there's a lot of subtlety, and frankly, even though we have guidelines, the one thing our guidelines do not tell us is exactly how to sequence one of our first-line medications in front of the other. And this is where the patient preference part comes in. You truly can't go wrong as long as you're incorporating the patient preference because these are all appropriate therapies, and we unfortunately do not have a magic wand to date to tell us exactly what is going to be the right therapy for the right patient just by looking at them.

Dr. Chovatiya:
For those just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Raj Chovatiya, and I'm speaking with Dr. Peter Lio about personalizing care and optimizing long-term disease control in atopic dermatitis and prurigo nodularis.

Dr. Lio, can you walk us through how fluctuating disease activity shows up in patients with atopic dermatitis or prurigo nodularis, and how that disease course influences your treatment approach that we were just discussing in such great detail?

Dr. Lio:
Thank you because that is also such a critical issue and why I'm always a little bit wary of people making a spot decision from a visit. So you see that patient on a Tuesday, and you have 15 minutes and you're evaluating how they look on that day. And I would argue that because this is a very dynamic disease that waxes and wanes, it's possible they could be crystal clear in that moment, but the last three months in between visits, they might've been miserable, and tomorrow, they might have a huge flare-up. So I always am very careful about that because of the waxing-waning nature.

I think the better way to approach it is to ask broader time period questions. And one of my favorite tools is the ADCT, the atopic dermatitis control tool, that really frames everything over the past week. So at least you get a week. And ideally, the patient might even be able to do that between the visits to give us a little bit of a sense of how they are doing. Because if they look great that day or they look terrible that day, that doesn't necessarily tell us what we're going to do next if that particular moment in time doesn't agree with the vast majority.

So I'm trying to get a sense of how they're doing overall. I'm trying to get a sense of that impact on quality of life and sleep. That's one of

my favorite questions to ask: How has sleep been? Because even if they look great, if sleep is bad, we need to do more. On the other hand, if they look pretty bad and they have an excuse—'we traveled yesterday' or 'we were by my cousin who has a cat, and boy, that really tends to flare me up, but I've been great'—I don't really want to make a change. That's going to really be the key piece. But when we get to that point where we're aware of that and we're asking those questions, then we make the decision with that in mind.

And also knowing that to make a change, it might take a few good months before we can make the next estimate, right? I think you and I both know that sometimes you'll start a treatment, and two weeks later they call and say, "I don't think it's doing anything," and it's like, well, it might take a little longer than two weeks for us to know because of, again, this waxing and waning nature of the ups and down.

Dr. Chovatiya:
You know, you touched on this idea of sleep, and that's a really important element of quality of life. How does quality of life, in general, shape your treatment goals for these conditions? And this, of course, includes anything related to social functioning, psychosocial health, and mental health; how do you incorporate this?

Dr. Lio:
The older I get, the more I realize all that matters. Not to say that the skin itself doesn't matter—it does—but in a way, the quality of life encompasses that. When I was younger, I was much more interested in objective stuff, and you can influence a patient. You can come in with a big smile and lots of positive energy, and it's true to some degree. Good clinicians know how to shape a visit. But that being said, to ask the patient really how they're doing, that's the key. And that quality of life impact is really going to be the key piece. I think that's going to tell us whether or not something's truly a success or just looks that way.

Dr. Chovatiya:
And you touched on this before, but I want to make sure we didn't miss anything because it's such a critical point now that we have so many treatment choices. When folks don't get to full control or begin to lose response after, let's say, doing pretty good on therapy, are there any other pearls you have when thinking about how you sequence and switch therapies in these disease states as it relates to anything from the mechanisms of the drug or the mechanisms of the disease itself?

Dr. Lio:
I think the big things for me are being ready to switch categories altogether. So if the IL-13s are not a good fit for our patient, think about anti IL-31 or JAK inhibition—I don't mean to give them short shrift. It's only because in my own experience, the JAK inhibitors are very powerful and very reliable, but they come with a few more strings attached. The discussion around safety and the lab monitoring does put them, in my opinion—and I fully appreciate that they could be a first-line for the appropriate patient who's not a good candidate for the biologics—more of a second-line treatment for better or for worse. So that's why I'm tending to focus on our biologics, but I really enjoy the idea that depending on what happens to them and depending on what their major issues are, you can customize and go back to a different category.

Dr. Chovatiya:
Well, that's a perfect segue to my last question for you, and in the last minute or so we have together, for those folks that you have on therapy and it's been a while, let's say, that they're either controlled or relatively controlled for a long period of time, how do you monitor that response over time and really help to make sure that you can keep up long-term disease control, the third hurdle in your very famous diagram of the hurdles of care?

Dr. Lio:
Thank you, yes. The hard part is them keeping it up and really being sure they're okay. I think the secret, and what we tend to do focusing on eczema, is we are in touch with our patients a little bit more. Especially after I think a lot of suffering, they're going to come in and check in more often. It might be every two to three months. So I'm really asking those questions: How are you holding up? Are we still where we need to be?

And in the past, we didn't have a whole lot of options. So if they said, "I'm not doing that well," it's like, "Okay, see you next time." There's not much we could do, but now, we can. We can say, "You know what? You've been on this particular biologic for a few years, and it sounds like it's not serving you. Can we talk about switching? Would you be up for trying it? Again, it's not irrevocable. If it doesn't work out for you, we can always go back." It's a lot of paperwork and maybe some headaches, but the safety of these and a relatively rapid onset allows us to try them to try to get the patient to that highest level of happiness and the least impact on quality of life—the best sleep, the lowest itch, and the clearest skin. I think we finally can start to explore that for each patient. And there are so many patients that have kind of given up, and when you offer these new options, they tear up and they say, "This is amazing. I feel like this is what I've been waiting my whole life for." And usually I say something like, "Me too."

Dr. Chovatiya:

With those insights in mind, I want to sincerely thank my guest, Dr. Peter Lio, for joining me in this discussion on personalizing care in atopic dermatitis and prurigo nodularis. Dr. Lio, as always, it was wonderful having you on the program.

Dr. Lio:
Thank you my friend.

Announcer:
This episode of *DermConsult* was sponsored by Galderma. To access this and other episodes in our series, visit *DermConsult* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!